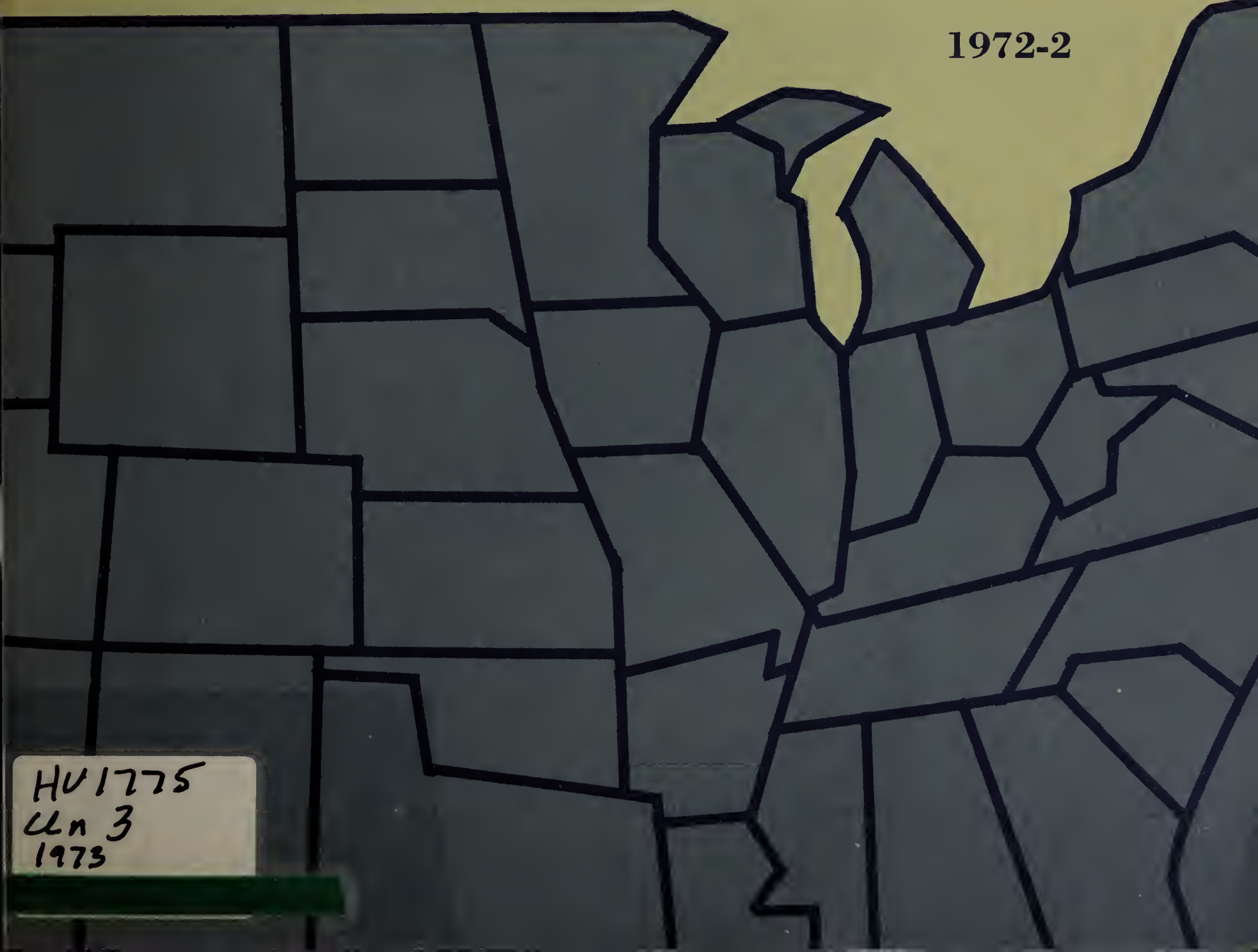
Some Current Concerns of Rehabilitation Facilities

SPECIAL REPORT

1972-2



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

INFORMATION MEMORANDUM
RSA-IM-73-32
December 1, 1972

TO : STATE REHABILITATION AGENCIES (GENERAL)
STATE REHABILITATION AGENCIES (BLIND)
STATE AGENCIES FOR DEVELOPMENTAL DISABILITIES

SUBJECT: SPECIAL REPORT 1972-2: SOME CURRENT CONCERNS OF REHABILITATION FACILITIES

CONTENT: SPECIAL REPORT 1972-2 is the second publication to be developed from the Third Annual Conference of the International Association of Rehabilitation Facilities, Chicago, Illinois, May 7-10. Similar in composition to Special Report 1971, it includes selected materials from general and special interest sessions as well as from the Institute for State Rehabilitation Facilities Specialists held on the last day of the conference.

The items in all of these publications have been selected in order to share contributions from the rehabilitation facilities, the State vocational rehabilitation agencies, the Federal agency, and others who have input into the rehabilitation program. We hope that the material in these publications will inspire innovation and improvement in our joint efforts toward the more effective rehabilitation of handicapped persons.

A limited number of additional copies are available from:

Division of Service Systems
Rehabilitation Services Administration
Social and Rehabilitation Service
U.S. Department of Health, Education,
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for Frederick Sooby
Commissioner
Rehabilitation Services
Administration

SPECIAL REPORT
1972-2

SOME CURRENT CONCERNS OF REHABILITATION FACILITIES

presented at

3rd Annual Conference of International Association of Rehabilitation Facilities

Chicago, Illinois
May 7 - 10, 1972

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
REHABILITATION SERVICES ADMINISTRATION

Washington, D.C. 20201

DHEW Publication No. (SRS) 73-25052

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I. THE DYNAMICS OF CHANGE

Philip J. Rutledge
Deputy Administrator, Social and Rehabilitation Service, D.H.E.W.

In the Department of Health, Education and Welfare, our two major goals this year—the promotion of non-dependency and institutional reform—were selected and are being pursued to accommodate the dynamics of change.

Our non-dependency goal envisions reducing people's needs for public services and public assistance, as well as for drugs and alcohol. We are focusing on the prevention of need and helping individuals to become socially contributing citizens. We will, of course, continue to make services available to vulnerable persons who require special treatment or help. There can be no better use of public funds than helping people to rejoin society on a productive basis, although not all can achieve self support. In pursuing this goal, the rehabilitation process obviously will play an integral role in its accomplishment.

Our second goal—institutional reform—is a natural complement to the first. We cannot achieve non-dependency without adjusting means and procedures to mesh with the sweep of change. This goal assumes that we plan to increase the efficiency of indispensable services to guarantee that our programs are responsive to the true needs of the people we are dedicated to help. It probably will not have all we want in service reform. It does, however, open the door to a major advance in the provision of social services, including increased vocational rehabilitation activities.

We have issued a regulation to separate assistance payments and social services. This should lead to the establishment of different kinds of new social service agencies in the States and communities. These agencies will accelerate achievement of goal-oriented public social services designed to help families and individuals attain the maximum economic self-sufficiency and personal independence. A series of task forces in the Social and Rehabilitation Service are removing barriers in order to facilitate the progress that people can make up the ladder from total institutional care through community-based care through self-care to self-support.

We also are finding ways in which various categorical services can work together by being a little more concerned with the needs of the people we serve and not quite so worried about the categorical boundaries that we have built up over the years. The concept of integrated services is going to be our main thrust throughout the decade of the 1970's. We want to develop a network of cooperating agencies. As this network develops, we want people in need of services to be able to enter it at any point and receive prompt and proper guidance to all of the service needs they may have. Integrated services does not mean consolidation of all agencies—public, private and voluntary—into one super agency in which everyone is a generalist, but it does mean a higher degree of cooperation and service than we now have. Integrated services does not mean lessening of services to target groups to reinforce the actions that we are taking administratively.

Rehabilitation facilities can play a major role in the initiatives being taken by the Federal government. The vocational rehabilitation concept is a good example of the way that individuals can be taught to help themselves to a richer and more rewarding way of life. This approach needs to be instilled in the entire range of services—to make the goal of rehabilitation of the whole person standard operating procedure for our social services system.

We recognize that the need for financial support for facilities never seems to match the available funds. I doubt that any rehabilitation facility ever feels it has enough money to do the job it would like to do. I am sure that many of you feel dissappointed because the Federal government is not providing more support. This dissatisfaction is understandable, but it should not be considered all bad. We can turn it into a positive asset.

I want to share a few figures with you that indicate a high level of Federal support for facilities, even though it is not enough. In fiscal year 1971, the last year for which we have complete figures, the Rehabilitation Services Administration channeled nearly $163 million into rehabilitation facility activities. This amount includes case service funds spent through the State rehabilitation agencies, as well as a wide variety of project grant funds. Above and beyond this figure, are research and development grants that went to facilities, Hill-Burton funds for facilities, and Department of Labor funds. A review of these figures over the years shows a gradual and steady rise in dollars each year, and we expect to continue that trend.

We do know that these funds are doing some good because we have a record of rapid increase in utilization of facilities by State vocational rehabilitation agencies. The annual increases in case service funds have helped to spur this development. A sharp rise can be seen over the past four years.

In 1968, State rehabilitation agencies spent $55 million in facilities; in 1971, the figure was $96 million.

In 1968, the State agencies sent 101,000 handicapped persons to facilities for services; in 1971, they sent 194,000.

In 1968, fifteen percent of all clients served that year were sent to a facility for one or more rehabilitation services; in 1971, the percentage increased to 19.3 percent.

By 1980, it is conceivable that 40 percent of all clients served by the State rehabilitation agencies will be referred to facilities.

As we look ahead to the rest of this decade, the outlook for rehabilitation facilities is bright. There is no question but that they will be used more extensively in the coming years. Facilities will play an important role when new legislation is passed or as we implement more of the legislation on the books. Facilities will be involved in some of the incapacity determinations and determinations of VR potential. There is an increasing demand for long-term sheltered employment opportunities and I think we will see a significant increase in these kinds of employment opportunities during the next few years.

The expanded Wagner-O'Day Act should substantially increase the amount of government contract work going to workshops. I want to voice a note of caution, however, because workshops that engage in government contract work must show capability to handle the work and to meet deadlines. Contract capability must be improved if the potential of this Act is to be realized.

Passage of new VR legislation will also have a favorable effect. However, to assure this continuing progress, there must be marked improvement in the service delivery methods we find in rehabilitation facilities.

We know that we are not making the maximum use of rehabilitation funds because unnecessary duplication of services exists in some communities and planning for the use of funds has not always been adequate.

There also have to be better facts and figures developed on cost benefits. You will have to provide better information showing value received for the case service dollars being expended in your facilities. And we will have to document the benefits that flow from various kinds of project grants you receive.

We believe that improvements in these areas will flow from the programs of accreditation and development of standards that we have supported both in words and with money. As many of you know, the Council of State Administrators of Vocational Rehabilitation adopted a resolution a few years ago that encourages all facilities to meet national standards. The Council's Facilities Committee also adopted a resolution, in 1970, that by June 30, 1974 all facilities providing services to clients of State vocational rehabilitation agencies will have:

a. applied for accreditation to:

   i. Commission on Accreditation of Rehabilitation Facilities (CARF), or
   ii. National Accreditation Council (NAC), or
   iii. National Policy and Performance Council (NPPC)—for agencies applying for training service grants—or

b. applied for certification by the National Industries for the Blind (NIB).
c. Received an on-site survey from either CARF, NAC, or NPPC, or completed the self-study guide prerequisite to NIB certification.
d. Outlined written plans (by June 30, 1974) to meet accreditation no later than June 30, 1976.

SRS is providing significant financial support for both CARF and NAC. The next few years should show a substantial increase in the number of facilities accredited.

We also look forward to continuing improvement in communications between the Federal government and facilities in the years ahead. The National Policy and Performance Council is an important link between this office and the facility field. This national body is appointed by the Secretary of Health, Education, and Welfare and is staffed by the Rehabilitation Services Administration. Its membership of 12 persons includes

representatives of sheltered workshops, organized labor, State VR agencies, local or State governments, and the general public.

It is important that we succeed in all of these endeavors—facilities growth, improvement of services and standards, continued Federal support for facilities, and improved communications between us—because those who depend upon our success are vulnerable human beings, looking to us for support. People in need of help are the entire reason for our existence. If we fail to serve them because we are overwhelmed by the "dynamics of change" or for any other reason, then we are not attaining our stated goals of helping people to help themselves. Nathan Nolan, in the March-April 1972 issue of *Focus on Facilities*, wrote: "Rehabilitation is on the go—with facilities at the forefront. The direction is clear, the future is bright; but the world, too, is on the go and is changing. Rehabilitation facilities must move with it. . .together, the national forces for rehabilitation have an opportunity to bring hope and fulfillment to the lives of the nation's seriously disabled people."

To that I say "Right On".

I am glad that you—and we—are keeping our attention focused on the people and not the programs and problems. If we are to achieve an ever-higher degree of competence we must meet the enormous forces of change head on and shape them to serve the people who need our services.

This is the challenge that change presents to us, and I am confident that we have the ability to meet it successfully.

II. SERVICE PURCHASE AGREEMENTS BETWEEN STATE VOCATIONAL REHABILITATION AGENCIES AND REHABILITATION FACILITIES

The Council of State Administrators' Guidelines

Craig Mills
Director, Division of Vocational Rehabilitation, Florida

The Council of State Administrators of Vocational Rehabilitation recently approved the Guidelines for Working Relationships between VR Agencies and Rehabilitation Facilities. These Guidelines represent a considerable amount of effort over a period of time. The Rehabilitation Facilities Committee, under the chairmanship of Mr. E. Russell Baxter, worked through a series of subcommittees, and had the advantage of advice and consultation from RSA staff members as well as State facilities development staff. As a result, we have a concise 14-page document which attempts to set out some basic principles of working with facilities.

As they have been reviewed in the past few months by State vocational rehabilitation staff, some changes have been made. I am sure that as the States attempt to put these into practice there will be other helpful suggestions coming back that will help us to update these guidelines and to make them a viable document as time goes on. They are not set in stone and we expect them to be a changing dynamic document over the years.

The second point, and one which is probably an area of potential misunderstanding, is that the Guidelines are not Federal legislation or regulations and that the Council of State Administrators has no authority to force State vocational rehabilitation programs to take any special action or to follow a certain course on facilities or on anything else. We've operated over the years, I suppose, on the basis of mere pressure, of trying, in the Council, to use our best experience and to hold up to ourselves ideals that are worthy of copying throughout the country. We gave careful consideration to the principles and policies of the Guidelines, but we have no basis for mandating or forcing them upon any State.

All of us were pleased and surprised after the review of the Guidelines. There had been practically no objection within the Executive Committee and, while there were a number of questions raised on the floor when this was discussed at the business meeting, there were few voices in opposition. Although many may have had some questions about how some of these basic principles would apply in their States, I think this represents a rather strong concensus of the Council. We realized in setting the Guidelines that they may run contrary to some permanently established ways of operating in certain States, practices that have existed for a long time. Other States, with relatively new programs, not as bound by tradition, may not have to go through the trial and error methods of the older State programs, and may be able to use the Guidelines as the way to quickly become operational.

The Guidelines include the following sections: Functions of VR Agencies, Classifications of Rehabilitation Facilities, Accreditation of Rehabilitation Facilities, Sponsorship of Facilities, State Agency Facility Staff, Purchase of Services, and Definitions. We're talking here about the Purchases of Services section.

We feel that we're on the threshold of tremendous expansion in rehabilitation facilities, especially in those facility programs providing vocational adjustment services such as evaluation and work evaluation, personal adjustment, pre-vocational training and specific job skill training. It seems to be a fact of life that the demand for services will always run ahead of State and Federal resources to perform the job or purchase the services. With the emphasis on accountability and cost effectiveness, State vocational rehabilitation agencies are committed to the goal of using their limited financial resources in the most effective manner possible.

We feel that the statement of principles may help vocational rehabilitation agencies and facilities in developing better plans for the purchase of facility services. We realize that there is a need to develop adequate plans for all types of facilities, whether the program emphasis is physical restoration, vocational adjustment, social adjustment, sheltered employment, speech and hearing or whatever it may be. But possibly the greatest need for a planned system of this kind is in the area of vocational services, especially the workshops. Medically oriented or physical restoration facilities usually have been established by other agencies or components of government, and there seems to be a better historical pattern for the method of purchasing services by VR.

Therefore, we'll consider this section in the context of the purchase of services from rehabilitation workshops. Since this is a very short statement of just a page let me read it:

> "Ordinarily, the services of a rehabilitation facility have been purchased by the State rehabilitation agency on a "fee for service" basis. The traditional arrangements have not always worked out satisfactorily. It is the joint responsibility of the rehabilitation facility and the State rehabilitation agency to work out arrangements which will protect the interests of both and provide the most effective services for the handicapped people for whom they share responsibility. In this discussion, we shall concentrate upon arrangements of State rehabilitation agencies with voluntary rehabilitation facilities, since it is usually much less difficult for the rehabilitation agency to work out satisfactory arrangements with State operated facilities.
>
> The rehabilitation facility is generally governed by a Board of Directors selected from the community. Frequently, it sells services to other agencies in addition to the vocational rehabilitation agencies. Sometimes it is difficult for the voluntary rehabilitation facility to adjust its program to meet the needs of vocational rehabilitation agency clients. Almost always the voluntary rehabilitation facility will be raising a portion of its operating fund from the community. A few principles may be stated to guide State vocational rehabilitation agencies in making arrangements with rehabilitation facilities.
>
> 1. The State agency should accept responsibility for all reasonable cost associated with serving its clients in rehabilitation facilities. This means that the agency will pay on a "cost" basis for the services its clients receive.
>
> 2. The State agency must insist on paying only the cost for those services its clients receive. For instance, if a facility provides medical services and vocational services, and the agency is purchasing only vocational services, it cannot be expected to pay the total "per diem" cost of all rehabilitation services provided in the facility. The accounting system of the facility must be able to cost out the specific services which are being purchased by the vocational rehabilitation agency. Fortunately, accounting systems are now available which, if adopted by the rehabilitation facilities, make this kind of cost accounting practical.
>
> 3. The rehabilitation agency must recognize that a rehabilitation facility cannot serve rehabilitation clients effectively unless it can have reasonable assurance at the beginning of the year with respect to the volume of agency clients it will serve during the year. The "feast or famine" method of purchasing services is demoralizing to the rehabilitation facility and not conducive to the long range best interests of rehabilitation agency clients.
>
> 4. Rehabilitation agencies cannot operate on the basis that they will purchase services where they are cheapest; neither is it wholesome for rehabilitation facilities to be put in a position of competing for the State agency dollar. State agencies must evaluate carefully the scope and nature of the services they receive from each facility, and agree upon a rate which is fair and reasonable, taking into consideration all aspects of the rehabilitation facility's program and operation. For instance, sometimes it may be to an agency's advantage to pay a high cost to a rehabilitation facility during the years it is becoming established in a community. Later, when its operation has been stabilized, the agency would probably expect the cost of services in such a facility to approximate the cost in long established facilities.
>
> 5. It is the obligation of both the State vocational rehabilitation agency and the rehabilitation facility to work out carefully plans for the evaluation of services provided vocational rehabilitation clients. This is an important but difficult field in which research is badly needed."[1]

We hope these five statements of principles will become a starting point and foundation stone for an improved working relationship between facilities all over the country and State vocational rehabilitation agencies.

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[1] Council of State Administrators of Vocational Rehabilitation. *Guidelines for Working Relationship between VR Agencies and Rehabilitation Facilities.* Washington, D.C., 1972. 8-9.

II. SERVICE PURCHASE AGREEMENTS BETWEEN STATE VOCATIONAL REHABILITATION AGENCIES AND REHABILITATION FACILITIES

One Way to Purchase Workshop Service

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Several years ago, the Arkansas vocational rehabilitation agency conducted an outstanding project concerning the delivery of service in vocational rehabilitation. The report of this study, *This Is One Way*, is worth studying.[1]

This will be a discussion of *"one way"* for State agencies to purchase service from workshops. It is one version of what is popularly called "block funding," but a particular type of block funding which we believe has special merit. In California, we call it "contract purchase of service."

Block funding isn't a new concept. It usually refers to the purchase of services a year at a time for a group of clients. Many States have tried one or another system of block funding. Claude Whitehead of the Michigan vocational rehabilitation agency did a study last year in which he found, among other things, that twenty States had some form of annual agreement or contract with rehabilitation facilities. However, in his survey, Mr. Whitehead found that, of the twenty States, only six reported positive attitudes of counselors, nine reported *mixed feelings* on the part of the counselors, two States did not know what the counselors' attitudes were, and three States reported *negative* counselor attitudes. Six other States without annual agreements also reported negative counselor attitudes toward the idea of such agreements. Significantly, Mr. Whitehead suggested that the negotiations *"always" involve the counselors.*[2] In California, we believe that the *key person* in this type of agreement or contract is the State agency counselor in his role of "purchasing agent."

Let me briefly recount what led up to a pilot project in contract purchase of service. For some fifteen years, the State rehabilitation agency has been purchasing services such as work evaluation and work adjustment from workshops on an individual fee per client basis, established essentially in an arbitrary manner. Although the fees have been adjusted from time to time, there have been many deficiencies in this method of purchasing workshop service. A problem that has occurred also in many other States is that when State agency counselors run out of money near the end of the fiscal year, they stop buying service from workshops. So we have a situation in which clients need services, the workshops are ready to provide them, but we can't purchase these services. This is wasting resources, and is detrimental to the clients. The workshops suffer. Their expenses are relatively constant but the income from one of their major customers, the State rehabilitation agency, is *not.* We have found also that the flat fee per client system results in some shops being underpaid and some being overpaid for the same service.

There have been *several* other criticisms from counselors in the State agency and from workshop administrators. The counselors complained that services provided by individual workshops frequently were different from services needed for their clients. Also, they frequently stated that costs for rehabilitation workshop services were excessive when compared with the value of services rendered. Occasionally, counselors indicated frustration with waiting lists and delays because of limited capacity in some workshops. Some workshops were accused of keeping clients in programs longer than necessary in order to increase the total fee income. They stated also that appropriate service to their clients in workshops was sacrificed in the interest of maintaining or increasing subcontract production in the shop.[3]

On the other hand, workshop administrators listed the following problems:

1. They found it difficult to budget and make staff assignments on the basis of income from the State agency, which might be extremely variable throughout the year.
2. They frequently claimed that the State agency encouraged them to hire professional staff and to establish rehabilitation services and then failed to utilize the services. This left the

workshops with the problem of finding other financial resources to subsidize the services that the State agency had requested.

3. They frequently reported that counselors referred clients without an adequate understanding of services which were to be purchased and without continuous participation with the working staff during the time the clients were in the shop.[4]

The last point was underscored in an article by Stanley Smits of Georgia State University, in referring to a problem area which he called the "shared-client." He said that:

> "Analogous to some family settings the agency-referred clients to a facility may be accurately referred to by the facility's counselor as 'my client,' 'your client,' and 'our client.' This situation develops because the clients are referred by a variety of State agency counselors. Some turn the client over entirely to the facility counselor. Others maintain full control over the client while he is in the facility. Still others share the responsibility with the facility counselor. The State agency's policy regarding this typically has little influence on how the counselor structures his relationship with the facility's personnel and what responsibilities he delegates to them. The State agency counselor decides for himself, and has the power to back up his decision, because he can always stop referring clients to the facility. Confusion over responsibility for the shared-client can be disastrous. It is possible that neither counselor will work with him because each assumes the other is providing whatever counseling is needed, or it is possible that both will work with the client thereby duplicating and confusing the process."[5]

This then was the setting which led our Department, in consultation with the California Association of Rehabilitation Facilities, to act. We first reviewed the various block funding agreements which had been tried in other States and attempted to learn what *was* workable and what *was not* workable. We then selected two large workshops in one geographical area and set up a pilot project. Briefly, this is the way it works:

The State agency contracts with the two shops to reserve a specified number of work evaluation and work adjustment stations for State agency clients. A preliminary estimate of the number of work stations needed by the local District Office of the Department is projected from data which is available, based on the previous twelve months' experience with the shop. This estimate is modified later by projected program changes. The quality and type of service to be provided is specified in terms of staff ratios, staff qualifications, reporting format, etc. The cost of providing the amount and type as well as quality of service specified is developed in a joint budgeting session with the administrative staff of the workshop and the local counseling and administrative staff of the District Office. This joint program planning and budgeting session is, in our opinion, the key to effective utilization of workshop services. It is the most critical part of this arrangement. The facilities specialist, of course, performs an important role in developing the background information and providing staff assistance to agency administrators. His participation in developing the contract also insures necessary minimum standards.

Now let me take you through the process step by step in the development of our pilot project.

Phase I—The Field Office, with the assistance of the Management Services Section of agency headquarters developed a list of the amount and type of service purchased from each workshop during the preceding twelve months.

Phase II—The local administrators and supervisors of the State agency and the facilities specialist evaluated the pattern of purchasing service over the period of twelve months.

Phase III—The workshops were contacted by the facilities specialist and the local District Administrator of the Field Office and were requested to make financial records and caseload statistics available to the facilities specialist for his review in developing approximate costs for the provision of rehabilitation services.

Phase IV—A meeting of workshop administrators, workshop counseling staff, State field office administrators and supervisors, a representative group of rehabilitation counselors, "the purchasing agents," as well as the facilities specialist, was scheduled. The meeting allowed the local Field Office staff to project, on the basis of the past year's experience and other relevant data, the amount and type

of service that would be needed during the following year. The workshop staff described the types and numbers of personnel, materials and equipment, and other factors they believed would be necessary to provide the services requested by the State Field Office staff. Information obtained by the facilities specialist earlier made it possible to develop a budget for the level of service proposed. This procedure gave the local Field Office staff of the State agency a chance to adjust the level of service and the cost of providing the service through mutual negotiation with the workshop staff, which was then formalized by a contract between the State agency and each workshop for the support of professional rehabilitation workshop programs of a quality capable of providing a specified amount of service. This resulted in the availability of workshop services to clients of the State agency at a cost which the field counselors felt was compatible with their overall program. It also assured the administrator of the workshop that the cost of maintaining services requested by the State agency would be reimbursed at a predetermined level on a monthly basis for a period of twelve months. There also was a built-in requirement for communication planning and agreement between State agency staff and the workshop staff.

Phase V—The workshop was required to submit the claims for reimbursement under a line item budget. Departure from such a budget required approval of the local Department of Rehabilitation Administrator.

Phase VI—At the end of ten months of a one-year contract, the State agency staff and the workshop staff will convene a meeting to review and evaluate the results of the contract. A new contract for continuation will be drawn up if it is found that the basic agreement is of practical value to all parties. Sufficient evaluation is built into the contract during the year to permit joint development of changes when found to be necessary.

Under our pilot project, we believe that the *effectiveness* of funds spent for workshop services will be greatly enhanced. For the first year it is predicted that the amount of funds spent for workshop services will remain relatively constant. During succeeding years, the amount of service and the cost to the State agency is expected to increase gradually. Sufficient management controls are incorporated so as to insure that problems are identified in time for corrective action. In summary, the pilot proposal (which the Rehabilitation Facilities Committee of the Council of State Administrators has incorporated into its Guidelines)[6] reimburses workshops for actual costs of providing services requested rather than overcompensating poor programs and underpaying quality programs, as well as providing a stable source of support to the shop for fixed costs incurred at the State agency's request.

We believe that a major difference in this type of block funding arrangement from many others is the involvement of the counselors. Counselors specify services for their clients. The local District Office sets aside the funds necessary for the contract at the first of the year. Each monthly invoice is prorated among the counselors based on the amount of workshop service the counselor used. There is a minor variation in the per diem cost of service from month to month, which is a function of the level of utilization. In our pilot study the level of utilization has followed the counselor's projections quite accurately, so the per diem rate has been relatively constant. No counselor, under this arrangement, will ever have to be encouraged to use services his client does not need for the sake of honoring an administrative agreement.

We realize that some will say that most counselors do not understand workshop services well enough to participate in the manner described. Again, Smits observes:

> "Top level administrators from the State agency and the facility groups often communicate well with each other, but the significant decisions regarding client services are made in large measure by the non-administrative personnel in both settings. These personnel are often grossly ignorant of the finer points of each other's operations. Typically, their information is limited to that which can be acquired by touring the other's physical plant, by being introduced to their counterparts, and by reading the printed material describing policies, procedures, and areas of service. Direct observation of the other's services over a significant period, frank statements of assets and limitations, and an operational understanding of each other's policies and procedures are the exceptions not the rule."[7]

Rather than an argument against our project, we believe that the matter of the lack of understanding on the part of the State agency counselors is a supporting one. What better way to educate State agency counselors about workshop services and what is involved in manpower, equipment and other costs than to engage in the kind of deliberations included in an effort which leads to the contract purchase of service?

Some may be curious and even skeptical about a program which has been running such a short time. We have been evaluating the project closely and have come up with preliminary answers to important questions about the project. Some of the questions are:

> Can the recurrent annual fiscal crisis faced by workshops be eliminated through annual contract procedures?
>
> Can workshop programs be made more responsive to the counselors' needs?
>
> Can counselors accurately project their need for workshop services?
>
> Can workshops' costs be projected accurately?
>
> Can the necessary administrative problems associated with the purchase of service under an annual contract be resolved?

Our preliminary answers to all of these questions are in the *affirmative.*

So far, the State agency counseling staff has accepted the project. This can be measured in terms of overall utilization by the number of counselors using the service. Not only did the amount of services gradually increase in both workshops over the period since the pilot project began, but thirteen out of fifteen counselors have made use of services in one shop and twelve in the other.

In evaluating the program, we are collecting routine monthly service reports to enable us to analyze the effect of work adjustment services in terms of successful rehabilitations. The effect of work evaluation services can also be measured by comparing the success rate for clients who have been evaluated in the shops with a similar group of clients accepted for service without benefit of evaluation services.

Finally, a few words about what we do *not* expect from this pilot program nor from any contract purchase of service agreement. We do not expect that the State Department of Rehabilitation program will be redirected from its primary goals. We do not expect that this program will pay for extended employment. We do not expect that the rehabilitation counselor's responsibilities for his clients will be reassigned to anyone else. We do not expect all workshop services to become standardized. We do not expect an immediate increase in the amount of funds spent for workshop services and we do not expect to reimburse workshops for costs they incur for programs for other customers or purposes. This is a program to provide the highest quality of service where needed—when it is needed—and to reimburse shops for their actual costs of providing service to rehabilitation clients of the State Department of Rehabilitation.

We believe that contract purchase of service systems will provide the means for a much greater mutual understanding of the programs of the State agency and the facilities. If, as Claude Whitehead indicated, the romance between the State agency and the rehabilitation facility is floundering,[8] this is *one action* we would recommend be considered to keep the romance alive for the benefit of all concerned and, most of all, the client.

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[1] Rehabilitation Services, Department of Social and Rehabilitative Services, Arkansas. *This Is One Way* (Final Report of a Demonstration Project). Little Rock, Arkansas, 1961.

[2] U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Rehabilitation Services Administration. *Special Report 1971: Sessions for Rehabilitation Facilities Specialists.* Washington, D.C.: DHEW Publication No. (SRS) 72-25009, 26-27.

[3] Council of State Administrators of Vocational Rehabilitation. *Guidelines for Working Relationships between VR Agencies and Rehabilitation Facilities.* Washington, D.C., May, 1972. 9-10.

[4]*Ibid.* 10.
[5]Smits, Stanley J. Beyond the Buyer-Seller Relationship. *Journal of Rehabilitation,* 36:2, 28.
[6]*Guidelines.* 10-12.
[7]Smits. 28.
[8]*Special Report 1971.* 5.

III. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

Council of State Administrators' View

E. Russell Baxter, Commissioner
Arkansas Rehabilitation Services

I've been working with the Council of State Administrators' Committee on Accreditation for something over 3½ years now and will be referring quite closely to the Council paper throughout the presentation.[1]

The States' Council position is not a mandate. It is an idea, a goal, a principle. I'd like you to think of it in those terms.

There are several ways to view accreditation. From the Council's point of view or from the DVR Director's point of view, we realize that we ought to accept a listing of agencies certified to perform services as needed. The Council looks at this as possible in 3 ways: (1) Through DVR agency certification. Many States have fine standards. We are pleased to report this after having looked closely at the standards of the State agencies throughout the country. One of the State agency systems of accreditation will be represented here. (2) The second way is through State licensing. This is used particularly for mental health facilities but to a certain extent with rehabilitation facilities and workshops. And the third method (3), which the Council accepts as the only method in long range development, is voluntary accreditation. This is the concept of a voluntary agency set up specifically for the purpose of accreditation, operating independently from the facility it accredits. I think that we can look at this most clearly in terms of two of the standards. This is not selecting these two standards as more important, but only perhaps a little more critical. The first is health and safety.

It's inconceivable that we have gone as long as we have without appropriate attention to health and safety standards. We have done this only because we have not been mandated to do otherwise. The second standard is quality of services. This has always been important, but again we've been measuring it on a purely subjective basis. I don't know how we can wait any longer to assure ourselves that services are appropriate. So let's consider why standards are mandatory in the terms of these two.

In accrediting, to assure these two standards as well as the others, we have to consider possible significant variables. The first is emotional measurement. There can be no emotion in the application of standards. There must be as little subjective judgment as possible. Extraneous pressures, political or otherwise, affecting our decisions relative to the standards should be eliminated. We must have unprejudiced, independent judgment. This can only be done with the type of accreditation I am talking about—voluntary accreditation. And again I think it must be mandatory for the reasons I mentioned. It's not mandatory now. The Council paper did not make it mandatory. But it must be, in my opinion, in the same way that hospital accreditation or the accreditation of educational systems is mandatory.

In our facilities we have the possibility for a sound accounting system, the possibility for assuring appropriate services. This has always been important, but it's becoming increasingly important. You can relate it to Medicare, to Medicaid, to the insurance companies, to other third party programs, to the purchase of service agreements under Title IVA and Title XVI of the Social Security Act. And it is related to the approval of RSA grants.

We are talking about voluntary accreditation. We're talking about independent judgment, but we're not talking about objective judgment in isolation. These standards must be judged by representatives of facilities that operate the facility programs, and by practitioners providing services to clients.

CARF would be a good example of voluntary accreditation. The CARF board includes representatives of IARF, the Easter Seal Society, Goodwill, NRA, National Association of Hearing and Speech Agencies, and the Rehabilitation and Chronic Disease Division of the American Hospital Association.

These representatives of organized programs, operating facilities, and practitioners can review standards, can modify them and can and do prevent the possible isolation of a totally independent organization.

Let's look a little more closely at what the Council considers an accreditation agency appropriate for accreditation of rehabilitation facilities, considering specifically the resolution that passed last May after some modification. There will be additional modifications.

Let's look at what from the Council's viewpoint is regarded as an accreditation agency appropriate for the accreditation of rehabilitation facilities:

"1. The accrediting agency is national in the scope of its operations.

2. The accrediting agency serves a need which is recognized by a large proportion of the facilities it would expect to accredit and by the rehabilitation movement in general.

3. The accrediting agency performs no function that would be inconsistent with the formation of independent judgment of the quality of a program.

4. The accrediting agency makes available to the public the standards and criteria it uses for accreditation purposes, makes regular reports of its operations, and lists the facilities it has accredited.

5. The agency encourages and gives staff guidance for self-study prior to accreditation.

6. The agency uses an on-site examination as a basis for securing sufficient and pertinent data concerning the quantitative and qualitative aspects of the rehabilitation facility program.

7. The accrediting agency has an adequate organization and effective procedures to maintain its operations on an ethical basis.

8. The agency reviews at regular intervals the standards and criteria by which it evaluates facilities.

9. The accrediting agency has had enough experience to indicate its competence to do the job it sets out to do."[2]

The Council has re-endorsed the resolution of 1970 (included in Mr. Rutledge's presentation). It modified it in one way by listing the criteria for the appropriate agency to actually accredit facilities. We are now studying and expect the Council to approve additional modifications which will take into account the newly established facility with the requirement of the use of appropriate State standards for a 3-year period. This is where State standards, in the view of the Council, can be most important. They will not only provide necessary certification for the first 3 years but also State facility staff can provide intensive technical assistance and recommendations relative to improvement of programs within the 3-year period so that the national standards can be met by no later than the end of the fourth year from the date of admission of the first client.

The Council also accepts the need for improvement in the present voluntary system with relation to effectiveness, to follow-up, to accountability. Oklahoma and other States are now studying this, in order to develop a system for measuring effectiveness of particular facility programs. This is important.

The final reason for the necessity of voluntary accreditation is dictated by the critical nature of the facilities specialist's job. I'm disturbed at the emphasis, or lack of emphasis, some States have placed on the role of the facilities specialist. The facilities specialist first must relate to the traditional program of rehabilitation.

When you add to this the increasing responsibility under new legislation; if we have authority for the severely disabled, or if we have certification of disability, the facilities specialists' role will be increasingly important. In my opinion, this role should not include the evaluation and certification of facilities as meeting certain standards. I think the facilities staff has a more complex role than time will allow without entering into certification. Relating closely to this, if a State agency has on its payroll the staff that it takes to properly survey, accredit and maintain standards, I have a strong feeling that, when costs are compared, this will be the expensive way to do it.

The Council committee took this into account. The Guidelines enunciate the Council's belief with reference to the role of the facilities specialist.[3] Perhaps this will help the States to become more aware of the facilities specialists' role and to give it the status it requires.

So, yes, I think accreditation is mandatory. Perhaps the Council and/or the facilities have set up too great a challenge. The Facilities Committee received some "flak" because of the resolution. Surprisingly enough it came from the State agencies primarily and not from the facilities. But we expect this and can address ourselves to it. It's too important to delay any longer.

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[1] Council of State Administrators of Vocational Rehabilitation, *Guidelines for Working Relationship between VR Agencies and Rehabilitation Facilities,* Washington, D.C. 1972.

[2] *Ibid.* 5-6.

[3] *Ibid.* 7-8.

III. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

A State Director's View

Craig Mills, Director
Division of Vocational Rehabilitation, Florida

One of the things we need to stress with regard to accreditation is that it begins in the field. It hasn't been government imposed. CARF's accreditation procedure really is a culmination of the work done by ARC, by Goodwill Industries, by the National Association of Hearing and Speech Agencies, and is a product of much of what had been done in hospital accreditation through the Joint Commission on Accreditation of Hospitals. We really have accomplished the American way of doing things by establishing, within the profession itself, some measure of pure review without waiting for the government to impose controls. And while both CARF and NAC have been sponsored with grants from RSA, I think everybody connected with the movement could say with a clear conscience that there has been no governmental intervention in terms of standards themselves.

With reference to one of the most important reasons for accreditation, the health and safety of clients served, I think it's remarkable and perhaps lucky that we have not had tragedies in terms of massive fires in workshops and facilities such as those that have plagued the nursing home industry. Many of our facilities started out in very old warehouses, some in multi-floor buildings that were not safe. One of the good aspects of the standards is the weight placed on health and safety factors for clients. And while some facilities, in doing self study, have felt somewhat burdened by the rather stringent requirements on safety, the necessity for this should be recognized. We can't afford to remain in business if we can't protect the health and safety of handicapped people who might not be able to handle themselves as well as non-handicapped in an emergency, an explosion, or a fire. The importance of having facilities that are free of barriers and that are protected with adequate fire measures is extremely important.

In regard to the matter of assurance of quality service to clients, what functional change takes place as a result of people being exposed to your services in rehabilitation? Both State rehabilitation agencies and rehabilitation facilities need very much to begin to adapt themselves to a methodology that will enable them to be accountable for what happens in terms of services rendered to clients. The greatest need is for an adequate system of records, so as to be able to lay a trail of what happens, to identify the findings on an individual and to have these available readily so that staff/team members can share them. This would also be a record of the kind of planning that was done, and of goals that were set. What services were rendered towards achieving these goals? What happened by the time the client left the program?

The same need faced hospitals in the old days and was one of the major reasons why hospitals were not accredited. Many people said: "It doesn't really matter whether you do paper work, as long as your patient gets good services." We've said the same thing over and over again in the facility program. But who is to say whether the services were good unless there's a record of what happened and somebody can review them and make a judgment that previous actions, based on adequate evidence and information were not subjective opinions and appraisal, and that good quality service did take place.

One of the other important considerations in terms of standards is to give some emphasis to the organizational structure of facilities. Many of our older facilities were excellent because of the personality of a director. But when we began to look at the facility-board relationships, we found that the boards had never met. Or there was not an adequate delegation of responsibility to department heads or units within a facility. And these are fundamental needs if a client is going to get good service. The board must function in such a way that it is aware of its responsibilities, of how it accounts to the community and to contributors. The board should be able to delineate the duties of a director, and to be sure that everybody else in the facility has an understanding of what his role is, and what his performance is to be, as well as the establishment of adequate personnel policies and procedures. Until this was laid out in a set of standards in an organized way, many facilities did not follow these practices.

Perhaps one of the most controversial problems has been in the area of staff qualifications. Many facility directors have said: "None of my people have degrees or have had specific training, but I'll put them up against anybody performing a like service in the country." We know this is true in many areas where there aren't qualifications delineated in the ways that they have been in medicine, in nursing, in OT and PT. But if we're going to be able to build public confidence in our rehabilitation facility program, we're going to have to account for the qualifications of our rehabilitation counselors, our work evaluators, and other staff in social adjustment and work adjustment functions in the same way that we've been able to account for the qualifications of other professionals. This is going to be a necessity in our procedures.

We've already referred to the problem of the adequacy of physical facilities with regard to health and safety. Additionally, while a good program may primarily depend on staff, it's hard to get and keep good staff and a good program going without at least minimum physical facilities. Standards have helped boards to learn what's needed in these areas and to be willing to make the physical changes and improvements that are necessary.

One of our greatest weaknesses in the area of accountability has been in followup—both in facilities and in rehabilitation agencies. I think increasingly as we boast about what we've done or attempt to justify what we've done, we're going to have to be able to account not only for the status of the individual at the time he's "closed" in the rehabilitation agency but what happened to him a year, or 3 years or 5 years later and whether the services we rendered really were meaningful in a long term sense in meeting his particular needs.

All of these are concepts built into the standards of accreditation and I think are essential and extremely important to us.

We've gone through a period in this post war epoch when hospitals have had the same problem of becoming accredited. Many good hospitals complained about the necessity of having to meet the standards of the Joint Commission on Accreditation of Hospitals. But this has paid off now as Medicare and Medicaid have come into the scene, and as third party purchasers increasingly are buying hospitalization services. And as rehabilitation facilities are opened up to payments out of Medicare, Medicaid and National Health Insurance, if and when it comes, and as an increasing share of State rehabilitation agency funds are invested in purchases of services from facilities, it's natural that we're going to have some demands placed upon us by State legislators and by the Congress, to account for whether or not we're buying services from facilities that can provide a quality service to clients. Undoubtedly a measure of the determination of whether we're buying quality service would be whether or not we're purchasing them from accredited facilities.

I'm sold on the value of accreditation myself, and I'm in complete harmony with the recommendations made by our Council of State Administrators in 1970, that we take a positive stand in moving towards accreditation. We tried then in the resolution we passed to set a goal in the movement towards accreditation. This has been mistakenly interpreted as a refusal on our part to utilize any facility that was not accredited. It would be impossible in this evolutionary period. We will always have new facilities coming along that will have to be supported and encouraged during the transitional period before they can become accredited. I think there will always be room for use of a non-accredited facility under these conditions. But for the long established, well financed, well operated facilities who could move towards accreditation, and even for State owned facilities, we felt the need to take a positive move to set some deadlines in order to achieve accreditation by certain dates.

I think RSA has a moral obligation not to give grants to any facility that cannot show that this grant will be used as a positive step towards accreditation. I don't think RSA will ever be able to completely withhold grants from other than accredited facilities. Part of the grant mechanism is to help a facility advance, improve and move ahead. But increasingly RSA and State rehabilitation agencies are going to be in a position where they are going to have to say to facilities: "We can't use you, or can't give you a grant or can't buy services from you unless you at least have a plan to move forward towards accreditation." I think in terms of exercising our responsibility to handicapped people, accreditation is the best thing in the facility movement that's come along in a long time.

III. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

A State Rehabilitation Facilities Specialist's View (I)

Harry W. Troop
Deputy Director
Facilities Planning and Development
Illinois

My initial understanding of the topic for this discussion was "Alternatives to Accreditation." To that I was prepared to say that to my way of thinking there is only one alternative to accreditation—that is, a state of three "c"s—chaos, contradiction and conflict.

Prior to facilities planning, we in Illinois had no systematic approach to application of standards, accreditation, classifications, fee ranges, etc. Our fees were set by the old method called horsetrading. The facility tried to get as much as it could and we tried to pay as little as possible. Somewhere in between we usually found agreement.

There was no way of comparing one program of services against another, no way of measuring the quality of any program. With only twenty-six facilities, we were rapidly approaching the state of three "c"s. Today, we work with almost seventy privately operated facilities and I would hate to think of the situation in Illinois had we not undertaken a systematic approach more than four years ago.

We think we have a good system in Illinois. There are advantages and drawbacks. First, I want to clarify two or three points in order to establish a common ground of understanding as well as the boundaries of my message.

1. When I refer to accreditation of facilities and what we do in Illinois, I am referring to the vocationally-oriented facilities, the workshops, because the medically-oriented facilities in Illinois do not fall within the responsibility of the facilities section and our standards are not related to them.

2. When I use the word "accreditation" I use it in its broadest sense to mean a number of things—approval, licensing, certification, or whatever other synonym you might use in your own State. In Illinois, we use the term "recognition." Whatever you call it, I am referring to that process whereby the relative quality of a program of services is determined and that program approved for use by the VR agency.

3. I am *not* opposed to accreditation by CARF, NAC, or any other recognized accrediting body. The position I have taken has been, is and will be that I am opposed to any action that could ultimately result in RSA mandating to the States how facilities shall be accredited and what accrediting body shall do it.

As briefly as possible this is what we do in Illinois. During the period of facilities planning, as mandated by the 1965 VR Amendments, we developed our own set of standards—"criteria" we called them. These were, to some extent, a modification of the standards developed by RSA, but with our own additions and deletions. We developed them with the advice and consultation of a committee of workshop directors. Each revision involves such a committee.

We, also, established five classification levels—Provisional (good for only 1 year), Level 1, Level 2, Level 3 and Level 4, the latter being the highest.

We established weekly fee ranges for all levels.

$20.00	Provisional
$25 - 40	Level 1

$35 - 50 . . . . . Level 2
$45 - 60 . . . . . Level 3
$55 and up . . . . . Level 4

Note that at Levels 1, 2 and 3 we have considerable latitude within which we can operate. For instance at Level 1 we can pay $25, $30, $35 or $40 per week. Evaluation could be $35 or $40 and work adjustment $25 or $30. A facility can stay at any given level for three or four years and still be entitled to increased fees. It is not necessary that a level change take place in order for a fee change to take place. There is no upper limit placed on Level 4 facilities. At the present time, the most we pay any facility for any service is $90.00 per week. All payments are on a per case basis.

A facility at Provisional level has one year in which to make Level 1—if it does not, we drop it from our approved list unless there is strong evidence to indicate that Level 1 can be reached within a very short extension period. We apply the standards each year to Level 1 facilities, every other year to Level 2's and every third year to Level 3's and 4's. We retain the prerogative of applying them at any time that we feel that changes in program, physical plant or personnel might adversely affect the classification. The facility, on the other hand, has the privilege of requesting the same when the director feels that the reverse is true, that an upward change of classification will result.

In case of the latter, we have one restriction—there must be at least six months between applications of the standards.

Naturally, we have a built-in grievance procedure. The first four years, we completed all the applications during February and March so that all details and documents could be expedited in order that all changes in classifications and fees could be effective on July 1. All of this material is included in our Casework Manual.

However, this year we have changed the procedure. We have divided the State's 8 regions into 4 groups of 2 regions each and apply the standards to 1 group each quarter of the year. Thus, it is now an around-the-calendar project, with four Casework Manual changes rather than one massive change.

We have a facilities supervisor and four facilities coordinators in our Facilities Section. They apply the standards. Usually one coordinator does it, inviting the appropriate DVR Regional supervisor or his designee to be present. Sometimes a team of coordinators is involved in some of the larger and more complex programs. The coordinator applying the standards is never the same one who has that particular facility as his year-round responsibility.

We have developed a system of correspondence, communications, monthly client reporting and annual inventory—all of which are tied in with this process.

Now that hundreds of applications of the standards have been made with virtually every possible result and/or situation involved, how do we see it? What are the advantages and disadvantages of ours, as a State agency, being the accrediting body as compared to a national voluntary agency?

First, the advantages.

1. Our standards are developed to meet the needs of Illinois and in such a way that allowances can be made for the differences and uniqueness peculiar to a given facility. Because of the wide range of population concentration, economics, social standards, etc., that exist between Cook County to the north and Cairo at the south, we find that this flexibility is absolutely essential. Because of this needed flexibility just in Illinois, it is most difficult for me to envision one set of standards for a voluntary agency as being equally applicable to such vastly different States as New York and Wyoming or Minnesota and Mississippi.

2. The people applying the standards are aware of the needs, the differences, the demands, the economics and the disabled population of the area served by the facility. Again, it would seem to me that it would be difficult for a consultant from a large facility in New York City, for example, coming into a facility in Carlyle, Illinois and being able to establish common ground of

communication, let alone an understanding of the community and its needs.

3. Our standards and the five levels of approval open the door for approval of any facility that has a sincere desire to upgrade its program of services as fast as it can over a period of time. Our standards make it possible for us to support this facility in its efforts to make these improvements. The standards provide a blue print for growth, a course to follow, a schedule to be maintained, and the readily available assistance of our coordinators to help them travel this course of improvement and growth. We rule in at the Provisional level many facilities that would never make it with application of national standards.

   I'm convinced that if all facilities were required to meet the one set of standards of a national agency, more than half would fall by the wayside—never make it, might forget the whole thing. Not that our standards are less, but rather that we have established levels, not just a black or white, yes or no result. It would seem to me that our follow-up capabilities to assist facilities in eliminating deficiencies at the level to which they aspire is far more advantageous than having a team come in, survey, make its report and recommendations and then not be around to help the facility do anything about it.

4. It is a good learning experience for the facilities coordinators. Over a period of time each coordinator surveys every facility in the State except his own, so that he then has a very broad understanding of the total network of workshop services available across the entire State and can relate this in meaningful terms to the facilities within his assigned territory. I doubt that this learning experience would take place under any other surveying procedure.

5. It does not cost the facility money. Under a system of charges developed by a national agency, I feel that many small facilities with good potential would not want to spend the money and would decide to stay at the activities center level, thus denying themselves the opportunity of a working relationship with us.

6. It assures the agency that the Regional supervisor or his designee becomes very familiar with the programs of the facilities within his Region.

7. There is a greater degree of uniformity. With only five people applying a given set of standards, it is almost assured that there will be a greater degree of uniformity in that application. Dozens of people were involved, regardless of how much training or indoctrination is given them.

Now, for some disadvantages.

1. It takes personnel, time, effort, perseverance. This costs the agency money. If a national agency were involved, the coordinator would have more time to devote to other things.

2. Possibility of personality conflicts and vice versa. If conflicts develop between the Facilities Section and workshop personnel, particularly the coordinator applying the standards and the workshop director, it is possible that the outcome of the standards could be biased, unjust, subject to disagreement by the coordinator responsible for that facility. The reverse could be true, too, a "buddy-buddy" relationship could have just the opposite effect.

3. Political pressure could be exerted upon the Facilities Section, before or after application of the standards. This could happen, I suppose, if a national agency were involved, but it is not as probable and not at the local level. We had one "go-around" with this type of pressure, which was applied without need, because the facility came out all right anyway.

4. The facilities get together and talk. They soon find out who has what classification and jealousy and hostility can develop. A facility can then jump on our backs, saying: "Such and such is Level 3; mine is just as good as his and I'm only Level 2." And so on. With a national agency involved this possibility probably would be less frequent.

5. If the State agency approves a facility, that facility can interpret such approval as a commitment on the VR agency's part to utilize the facility, to keep a specified number of clients in it at all times.

This is actually the way some regard it. And perhaps rightly so. We do have a commitment, particularly if they have upgraded their program, expanded, hired additional staff—all at our encouragement. This would not be so if a national agency were the accrediting body—although I am confident they would still twist arms for more clients. The difference would be in the reasons given for our being obligated to support them.

Those are the advantages and disadvantages of a State VR agency being the accrediting body rather than a national voluntary agency. I am not suggesting, recommending or encouraging other States to adopt our method. I present it as a procedure that we have developed, one that serves our needs and that is highly accepted by the facilities.

In facilities planning, RSA set the guidelines; the State chose its methodology. In comprehensive planning, RSA set the guidelines; the States submitted their planning design for approval and ultimately their individual plans. In this same vein, I propose that RSA *require* ultimate accreditation of facilities in order for State VR agencies to purchase services. But I feel that this requirement should be in such a form that:

1. By a certain date, each State agency submit to RSA for approval, its *plan* for the accreditation of its facilities.
2. Each plan spell out the procedure to be used, the agency to be designated and a copy of the standards to be applied. That agency might be the State agency, a national voluntary agency, a combination of both, or some other qualified, competent body.
3. Each plan designate the deadlines for such approval.
4. Each plan provide for an annual report to be submitted to RSA, detailing the status of the approval program and any changes being proposed or made.

RSA, in turn, would notify each State of the approval or disapproval of its plan.

If RSA would accept this idea it would provide for what I believe to be an essential ingredient in this matter of accreditation; that is, a matter of choice on the part of each State. If any program of mandated accreditation is to be successful, I believe that program must give to the State the right to choose, to develop, to plan, to implement the accreditation process to be utilized in that State.

III. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

A State Rehabilitation Facilities Specialist's View (II)

J. W. Cowen
Rehabilitation Facilities Specialist
Division of Vocational Rehabilitation
Alabama

As you know, it was not until the enactment of Public Law 565 in 1954 that State vocational rehabilitation agencies had the authority to expend funds for the establishment of facilities and until that time there was very little involvement with facilities by State vocational rehabilitation agencies.

Each State approached the establishment of facilities in a different way. In Alabama, we had, in 1955, only two facilities; in 1972 we have forty. In 1955, we spent only a few hundred dollars in facilities and this year we will spend over seven million. The State agency does not own or operate the facilities in Alabama. They are owned and operated by other public or private nonprofit organizations. The establishment of each facility was influenced by the State agency to meet the unique needs of vocational rehabilitation clients. We are aware that the needs of the clients vary in different areas of the State and therefore our facilities have to be geared to meet these unique needs. This is one reason I feel that we should have standards set for all facilities.

Accreditation, of course, means measuring up to or meeting standards. What is the value of standards, particularly for the use of a rehabilitation facilities specialist? I would like to list a few of them as follows:

1. Standards force the director or administrator of a facility to look at his facility as a business operation, both from the aspect of financial obligation and of services to people.
2. Standards are a method of fulfilling a long time desire of the facilities specialist to take a good look at facilities.
3. Standards give some framework to compare services within a facility and between facilities.
4. Standards provide the initial tool to examine and to determine accountability within a facility program.
5. Standards help the State know where to spend its money.
6. Standards help to determine services needed in a facility and/or the expansion of services within a facility.
7. When standards are imposed, the client can be transferred from one facility to another without interruption in his rehabilitation process and thus prevent what happens often, that when a client transfers from one facility to another his program will begin all over again with an initial evaluation.
8. Standards establish criteria, provide for inspection and certify for all users that a given facility has met such standards.
9. The fact of a facility's accreditation is beneficial to the facilities specialist in his responsibility for reviewing grant applications. At the present time, to be eligible for a training service grant, the facility must meet the standards developed by the National Policy and Performance Council. If a facility has been accredited by CARF there is little question but that it will meet the requirements of the NPPC.

Although no set of standards offers the instrument to review a program of services and really evaluate its effectiveness, I am afraid too many facilities, without standards as a guide, attempt to design an overall program and then expect every handicapped individual to adjust to that program. I am of the opinion that this can't be done. In Alabama we work as a team and as a team develop standards or accept standards developed by an accreditation agency and work together as a team to meet these standards. I find myself feeling that I am a member of the staff in every facility.

Henry Redkey in a speech to the 12th Annual Workshop of the Association of Rehabilitation Centers in December, 1963, said:

> "Accreditation properly administered will bring benefits to facilities. First, it will give the facility a badge of basic professional respectability, already earned in most cases but not always accorded. Second, and of great importance, it will pave the way for all types of third party purchasers to use the facility without fear of criticism—and don't for a moment underestimate the fear of criticism which plagues many organizations and agencies. Third, the process of attaining and maintaining accreditation will help executives, staff, boards, and communities to better understand the importance of quality in rehabilitation centers. These three benefits are worth struggling for and they are not to be feared."[1]

In the early years when accreditation was first being discussed, there seemed to be some hesitancy and fear of acceptance among some facility people. We should forget this "hang-up." In Alabama facility personnel accept the concept of standards and accreditation as a means of providing information that will help them plan more effectively.

Accreditation must be kept in mind in planning programs, staff development and facility expansion. Rehabilitation is changing from the medically oriented to a more holistic philosophy. Facilities in the future must adapt to the more complicated clients they will be serving. Accreditation will make it much easier for facilities to "tool up" in order to deliver services more efficiently and effectively.

As a facilities specialist, I feel accreditation is essential. I am not here to say who should be the accrediting agency, but I feel that all of us have a responsibility for suggestions and recommendations to the agency that is selected to set the standards for accreditation. The standards will need constant upgrading.

Accreditation, in my opinion, is a recognition accorded an institution that meets the standards or criteria established by a competent agency or association.

Accreditation has been generally accepted as the American way of bringing system and order into various types of institutions which serve the public directly. There appears to be no substitute for standards and the assets certainly outweigh the liabilities. As we continue to work together in this matter of accreditation and standards we cannot but improve our image to clients, communities, the public, and yes, even to ourselves.

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[1]Redkey, Henry. Accreditation Vital and Urgent for Rehab. Centers, Workshops, *Rehabilitation Record,* March-April 1964, 27.

III. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

An Insurance Company View

W. Scott Allan
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In preparing for this session, I concluded that you would have little interest in the personal views of one person in the insurance field—particularly one who is a member of the board of CARF.

Therefore, I took advantage of a knowledgeable, interested group of people in the field; namely, the Insurance Rehabilitation Study Group. This group of some forty-five individuals from major companies and trade associations in the Casualty, Life, Health and Reinsurance Sections of the business was organized about eight years ago. It is designed to provide a focus for rehabilitation knowledge and development among those companies and trade associations having interest and, in most cases, an operating rehabilitation program. Their involvement is in order to know what's going on in rehabilitation and for getting together for exchange of information.

With the permission of their current Chairman, I sent a questionnaire to the members. Of 34 companies represented, 30 replied for an 88% return, with the following results:

Question #1. Are you personally familiar with the program of the Commission on Accreditation of Rehabilitation Facilities (CARF) for evaluating and accrediting rehabilitation facilities (centers, workshops, institutes, departments of rehabilitation, etc.)?

Yes 29 No 0
Not Answered 1

(The conclusion can be drawn that all major insurance companies are familiar with the program.)

Question #2. Are your management and claims people familiar with it?

Yes 22 No 8

Question #3. Does your company use accreditation by CARF as one measure of the service quality or effectiveness of a particular rehabilitation facility?

Yes 19 No 10
Not Answered 1

Question #4. If yes in answer to #3, do you believe the accreditation process is a valuable component in your company's evaluation of and possible use of a particular rehabilitation facility?

Yes 16 No 5
Not Answered 9

Question #5. Do you use accreditation as a determinant in deciding on the use of one rehabilitation facility as against another of a similar type?

Yes 17 No 9
Not Answered 4

Question #6. If you do not think accreditation of facilities is necessary or valuable for your company's evaluation, why not?

1. Want company people to visit and evaluate facilities.
2. Check with other users of facility.

3. Judge facility on past experience with the service.

4. Place emphasis on acceptance by local physician.

5. Choice often limited by geographic restrictions.

6. Rely on International Medical Society of Paraplegia accreditation.

Question #7. Could the existing accreditation program of CARF be improved upon from your point of view?

Yes 19 No 6
Not Answered 5

if yes, in what ways?

1. Need indications of services available and quality.

2. Need to know if only total service or out-patient department for specific modalities available.

3. Too few accredited facilities yet available.

4. Need annual publication on services available and criteria for accreditation.

5. More publicity on standards and accreditation process needed.

6. Uniform record keeping and program effectiveness measurement needed.

7. Improved facility reporting and help on cost control needed.

8. Competence of facility staff on types of injuries should be designated.

Question #8. Would you and your people be interested in a cost/performance or service quality measurement schedule which would relate cost of specific rehabilitation services in a given facility to the duration and types of services needed for particular disabilities and to expected results (restoration of self-care, full or part-time employment, running own business, continuation of education, etc.)?

Yes 25 No 2
Not Answered 3

One can reasonably draw certain conclusions from this useful exercise. No insurance company is against accreditation, most think it is useful, however they feel generally that it could be improved in ways that would relate to facility service content, quality and cost in relation to end results obtained. It is also obvious that they would not rely solely on accreditation for evaluation and possible use of a given facility. Most companies feel there is no substitute for personal visits to a facility, discussion with staff, testing of results obtained by others who have used the facility—and indeed there is not.

Some additional general observations emerged in certain of the replies:

1. CARF should consider preparing and distributing annual reports on accredited facilities' performance.

2. A program should be initiated to request facilities which are accredited to indicate CARF accreditation on stationery, billing forms, reports, etc.

3. Designation by CARF of a representative in each State to whom users of facility service could turn for guidance and on problems arising with accredited facilities.

4. Can CARF help by insisting that facilities improve reporting procedures and general communication with third-party purchasers of services?

One detailed comment may be helpful:—

"Accreditation is important to develop a suitable organizational structure, essential services, qualified staffing, records and reports, good management and a safe and functional environment. It does not tell us, however, which facilities can provide the best program for various types of injuries such as brain damage, spinal cord, multiple amputations, severe burns, psychosomatic complications such as with low back pain. This information can be obtained only by evaluation of the program for each type of injury (and disease) and the doctors' interest and qualifications. I believe our great problem today is that we are unable to identify which facility does the job we want for the type of case we want to admit, unless we visit and talk to the staff. When the cases are national in distribution, this becomes very difficult.

I believe that each type of injury should have its own criteria as to what constitutes a total program. These criteria should be met before that type of injury can be accepted by the facility."

This observation pinpoints the greatest need of insurance carriers in the evaluation and use of rehabilitation facilities—performance guides related to ability to handle particular injuries or disabling conditions, staffing adequacy and experience, reporting and communication efficiency, cost of services related to modalities, standard treatment programs, professional evaluation and likely results obtainable. In all of this, we are not looking for ironclad guarantees but the development of information which can help us invest the rehabilitation dollars wisely and to the best interest of the disabled recipient of service.

IV. REHABILITATION FACILITY ACCREDITATION: POINTS OF VIEW

A Community Fund Agency View

Norbert Reinstein
Planning Associate
United Community Services, Detroit

From the point of view of the funding and planning agency that I represent, it is difficult to say whether we like accreditation or not because we don't know enough about it. However, in terms of answering certain questions that we have to ask frequently, it may be helpful.

In my capacity as a health planning associate, I am concerned with facilitating planning among agencies in health and rehabilitation. I also serve as a consultant to budget panels that allocate funds.

In the Detroit area, the United Community Services allocates about one million, one hundred thousand dollars a year to a variety of rehabilitation facilities. In reviewing these agencies, we ask questions that are related either to planning or to funding considerations.

With reference to planning considerations, we ask the following:

Why do some agencies have a clearly defined mission/and others do not?

Why do some agencies have a clearly written annual work program of their plans for the next year and how they are going to prove that they did it/and others do not?

Why do some agencies have clear-cut measurable objectives in advance of each year's programs/and others do not?

Why do some agencies have stable, well qualified staff/and others do not?

Why do some agencies have rather sound record systems that lend themselves to comparison/and others do not?

Why do some rehabilitation agencies relate very well to similar ones and manage to integrate their programs into an over-all community plan/and others do not?

In the area of funding considerations, we ask the following:

Why do some agencies incur increasingly larger and larger deficits and expect the community to pick up the deficit without much consideration about evaluation programs?

Why do some rehabilitation agencies have very solid agreements and purchase of service arrangements with the State agencies like the Division of Vocational Rehabilitation?

Why are some of the sheltered workshops filled to capacity, thereby reducing costs while others are half empty, thereby increasing cost?

Why do some of the facilities have a rather broad range of contracts providing a variety of experiences and added sources of income and others are limited in their contracts, and the work they perform?

Why do some of the agencies have a variety of sources of income, in addition to Community Funds and the State agency, like the WIN, Title IV, programs, etc., while others have only one source of income?

The following are 2 or 3 specific examples, when my agency was confronted with problems, where having standards for some measurable objectives and records would have been helpful rather than having to measure one agency against another.

About 3 or 4 years ago we were funding about 4 rehabilitation facilities. Some were doing fairly well; others were in trouble financially; others had a very poor image in terms of referral from the public agency (the

counselors felt they were not good facilities), and they were half empty. Evidence of the difference was that the State agency actually paid a different fee for the same procedures for each of the 4 facilities. We wanted to know why. Not having a clearly objective measurement, we commissioned our own management study, bringing in an outside firm to do a study for us. The study came up with certain recommendations.

We found that we needed to ask for very specific kinds of data in order to have comparable records, so that you can compare "apples with apples" and not "apples with oranges." Many of the agencies have a different method of counting what they do. Some count heads; some count services per hour; others count per day; and some count services that may be tangential to rehabilitation like social service, group therapy, industrial nursing, etc., so that actually one needs a clearcut system for comparison.

I think we could have used standards and some measurable outside kinds of norms had they been available in this particular instance.

Another example occurred about 2 years ago at 2 major rehabilitation facilities following the study that I just mentioned. Negotiations got under way at the Board level concerning the possibility of combining forces and perhaps doing things a little more efficiently. When they asked us to provide staff help in this undertaking, we assigned a member of our staff and again ran into the problem that the two agencies, in the same business, had a different way of defining their purposes and of describing their programs. Although they had the same way of analyzing their property and their funding, their personnel policies and personnel qualifications were different.

To have something measured, rather than measuring one against the other, an outside norm might have been helpful at that time. In spite of the difficulties, we did manage to work with them on the comparison and analysis. One of the biggest shortcomings that we found was record keeping, really sound records that could form a basis for self-evaluation and comparison.

As a result of this experience, the rehabilitation community under our auspices began a specific project, which lasted about 9 months, involving the public and private rehabilitation agencies which resulted, first, in a uniform nomenclature. In other words, when someone said "evaluation" all facilities talked about the same thing. When someone said "placement" all talked about the same thing. And when someone said "adjustment" all talked about the same thing. And that took some time even though some of the definitions are available nationally.

As a result of this project there was agreement between the public and the voluntary sector, which led to a record keeping system that was uniformly accepted, based on a 2-page record on every client. On termination of service, this is sent to the Research Department of my agency where it is placed on punch cards, processed and analyzed. Each agency gets a printout every 3 months and the entire group gets a printout of all the services for purposes of comparison. We have just issued the first 9 months of the printouts. I think it will be extremely helpful in the planning of individual programs within the agencies as well as in community planning for rehabilitation services.

There is one other area where I think some measurable data will be helpful, which my agency is now starting. Every fifth year, in addition to the annual budget review of agencies that are supported through the United Foundation Torch Drive, we plan to undertake a very intensive program review. That includes the objectives of the agencies, their mission, how and what they are doing in moving toward their goals, what they should be doing differently. I think again here, if there were measurable outside standards, they would be most helpful to evaluate instead of one agency against the other, each of the agencies against desirable goals.

So again coming back to CARF and accreditation, I can't say at this time whether we like it or not. However, if it can help us provide some of the answers to the questions that confront us then of course it will be helpful and we will be supporting it.

IV. PLANNING THE UTILIZATION OF REHABILITATION FACILITIES

By the State Vocational Rehabilitation Agency

Robert J. Wolfe
Chief, Facilities Development Section
State Department of Rehabilitation, California

I have been asked to present a description of how we use the State Plan for Rehabilitation Facilities in California.

Probably you will expect me to say that California is different from other states and that we in the Department of Rehabilitation plan our facility development very systematically and realistically and that we see to it that it works. Although, this has not been the case, we are taking steps to make it work that way.

That's what I'd like to discuss—making the plan work.

One of the critical steps we take after compiling our inventory of facilities (300 plus), by questionnaire and clerical tabulation, is to share all of this information with our facilities specialists who are assigned by geographical area. The facilities specialists then take this data and meet with the field administrators and the counselors in the local Department Offices. At that point, there is a systematic discussion concerning last year's development, existing services, and needs for development for the forthcoming year. We then incorporate this information into the State Plan which, as you know, is updated every year. This discussion with the local staff is most important. We are planning *with them* and not *for them*. We are supporting their efforts and we set down in print in the new plan the results of our discussions. Then it's up to us as facilities specialists, to work with local administrators to develop needed programs and provide technical consultation and grants as needed. It is our policy to work with the local District Administrator concerning any project proposal in its early stages of development to determine whether or not it will fit in with the local district plan. If it is a project proposal which was not anticipated—say a political project—we work to modify the project, perhaps to bring it into line with what is needed and make it of more value for the clients.

A second step in making the State Plan work is what we call a plan within a plan. In the Facilities Development Section, we have drawn up a yearly Operational Plan which spells out the objectives as well as the activities to meet the objectives within the State planning effort. We are in our second year of having an operational plan. This year's plan contains eleven major objectives, with various activities under each one. For example, recently, we transferred the State-operated workshops for the blind to the private sector and one of our objectives for this year is to assist the new private, nonprofit corporations to implement the new programs. Another objective is to improve grants management and under that we have listed several activities, including grants management seminars, in which we provide information to all new grantees concerning their responsibilities for conducting programs in accordance with grant applications and a description of the types of help that we can make available to them, such as accounting consultation and other types of technical assistance. We bring our auditing and accounting personnel to these seminars, and we invite representatives from the Federal Office to meet with the new grantees.

The third step in making the State Plan work is to develop a better system for evaluating applications for grants and establishing a priority list for funding. Our State Plan includes a description of this system. Our revised plan for this year will describe ten priority factors and also the method whereby we weight the different factors and assemble all applications in a priority order. What we have tried to do is to get away from the idea that priorities are based merely on population formulas. We do include such information in our evaluation but this is only one of ten factors. The ten priority factors are as follows:

1. Adequacy of planning.
2. Potential to continue following the grant period.
3. Level of Department of Rehabilitation field program support.

4. Level of community support.
5. Potential to serve special target groups.
6. Ability to administer grant funds.
7. Cost-benefit ratios.
8. Work base—this refers to workshop programs only.
9. Availability of service.
10. Disability groups served.

These priority factors are applied to proposals in the preliminary stages of development so that the Facilities Development Section and the various facilities can devote their primary attention to development of those projects which will be given the highest priority. Therefore, in addition to these priority factors, each facilities specialist is required to estimate the probability that preliminary applications and letters of intent will develop into completed applications with the necessary matching funds, appropriate titles to property, necessary community support, etc. This entire system, incidentally, was worked out in cooperation with the California Association of Rehabilitation Facilities.

We have been constantly working on our State Plan for Rehabilitation Facilities to make it a more valuable document. We have added descriptions of every type of facility grant including the purpose, duration, financial participation, types of expenditures included, application forms, application procedure, and additional references concerning the law and regulations concerning each type of grant. From time to time, we also include results of special studies. For example, we conducted a study on utilization of workshops and included the report in our State Plan. Our Appendix to the State Plan also includes our fee schedule, a roster of facilities personnel, and State agency standards for all types of facilities.

We use the State Plan as a means of orienting our Department staff which now numbers over 2,000 employees, and also in relation to meetings with many other groups we deal with in communities all over the State. It has become such a useful document that we went into a second printing this year. We will be ordering about 1000 of the new edition soon to be published.

Getting back to the original goal of making the plan work, we believe that there is a possibility of making the State Plan an operational system for facility development. We believe it is something we must do if we are to bring order and equity to the entire development effort.

IV. PLANNING THE UTILIZATION OF REHABILITATION FACILITIES

By the Department of Health, Education and Welfare Regional Office

Thelma Schmones
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Rehabilitation Services
Social and Rehabilitation Service, Region II
DHEW

There is a tendency to view planning only in terms of available grant funds, rather than planning within a broad perspective of the needs of clients. Federal Regional offices need assistance in determining these broad perspectives as well as specific priorities and targets. As you are all aware, the funds available in any one grant category have not been sufficient to totally fund an agency—so multi-funding (sometimes known as grantsmanship) has arisen. This concept of multi-funding can only be accomplished when the facts are known.

Therefore, a Regional representative, in order to assist facilities and agencies, needs to be aware of every community—its timing, its resources, its strengths, its weaknesses (much like clients).

Why do we need to know this? One of the reasons relevant to this discussion concerns the fact that Regional consultants change with the times as well. For example, now that university training programs have been decentralized, I have a major responsibility in this area as well. The manpower needs of the field—both state and non-governmental—also relate to the delivery system of services. Therefore, I need the facts—what jobs, what disciplines, where there are possible curriculum changes, etc.

My counterparts and I find ourselves on Regional Office task forces relating to the aging, WIN, welfare, grants management, drug addiction, alcoholism and so on. It is obvious therefore, that our best contribution to these groups as well as to rehabilitation programs is to be as knowledgeable as possible with reference to interagency relationships, political interests, size of the problem and so forth—and who is ready!

I would also like to restate a position I have long held. A facilities specialist is just that, a facilities specialist, not just a grantsman, but rather an individual who can provide the broad view to a community and help them place themselves in the total landscape. Just as the State agency needs a Statewide plan; each facility needs a plan, short-range and long-range, appropriately conceived and executed, with Board approval, including timetables and the like. Client services can only improve and expand with planning. Matching funds need to be gathered. Operational maintenance needs regular, not grant, sustenance. All of these goals and targets need planning. Your assistance and consultation is vital. We, in turn, will respond from our Regional drawing board, with the resources available to us, as well.

The Statewide Advisory Committees, established under the 1965 amendments, still continue to operate in Region II. These committees, representing broad rehabilitation leadership within the State, can be of inestimable value to you in determining priorities and goals for the entire State. This should be a shared responsibility.

The Allied Services Act implied the integration of service systems within a State. The utilization of other agencies and individuals to assist in rehabilitation is not new to us. Every client has at his disposal, a plethora of resources, depending on his needs. Boards of directors, professionally developed, represent major facets of the community. We have, in effect, the model of allied services already. What we will need, need right now, is the strengthening of community organization skills for facilities specialists and facility executives as we move ahead to meet our future challenges in these areas. Our experiences with model cities, welfare offices and the like has underscored this need. Our Facility Administration training program at Cornell has begun to incorporate these issues in its programs for facilities specialists, executives and their board members.

What started out from a position of surveying the data, developing grant guidelines and determining equitable distribution of funds, has grown to a position of consultation, catalytic and constructive, in assisting facilities to meet the needs of the disabled in a rapidly diverse and complicated world. The Regional Office is prepared to assist you to meet these new challenges. Together, not unilaterally, we will respond.

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